Mountain-Pacific uality Health Foundation

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"The best quality health care is provided to every patient we serve, every time."

Montana Medicaid Prior Authorization

Fax Request for Prescription Compounding Fee Determination

1. **Patient's Name:** _____ 2. **Date:** _____
3. **I. D. Number:** _____ 4. **D.O.B:** _____
5. **Compounding Pharmacy Name:** _____
6. **Pharmacy Phone #** _____ 7. **Pharmacy Fax Number:** _____
8. **Please list all ingredients and indicate if active or excipient – please attach additional form if >10 ingredients:**

Compound Ingredients

Ingredient Name/Strength	Active/Excipient?

9. **Final Form of Compound (cream, suppositories, suspension, etc.):**_____

10. **Level of Effort Requested (circle): Level 2 Level 3**

11. **Check applicable box for each category:**

A. Hands-on compounding time:
- o 5-15 minutes
- o 16-30 minutes
- o Over 30 minutes

B. Special equipment used:
- o Sterile field (laminar flow hood)
- o Unguator
- o Homogenizer
- o None of the above

C. Special considerations:
- o Complex formulation
- o Sterility testing
- o None of the above
- o Other: Describe under Additional Comments (#12)

12. **Additional Comments:**